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Larry Gostin is Executiv
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attributable to a single disease in the history of American jurisprudence.

AIDS litigation impacts powerfully upon many of the major social institutions of our nation—schools, health care, the blood supply, the judiciary, prisons, financing, and insurance. AIDS litigation has an equal impact upon our most cherished ethical, legal, and constitutional principles, such as privacy, confidentiality and the "right to know," freedom of speech and association, and liberty of the subject. AIDS litigation even reaches into our most intimate relationships, sparking cases within the family and against sexual partners.

This survey is written under a contract with the National AIDS Program Office of the U.S. Public Health Service. The report is presented in two volumes: *Objective Description of Trends in AIDS Litigation* and *AIDS Litigation Project: A National Survey of Federal, State, & Local Cases Before Courts & Human Rights Commissions. Trends in AIDS Litigation* describes the methodology used to collect case materials and the criteria used to select cases for inclusion. The rest of the volume summarizes trends in litigation across the country. *AIDS Litigation Project: A National Survey of Federal, State, & Local Cases Before Courts & Human Rights Commissions* includes the description of methodology, a subject matter outline, a discussion of how the cases have been organized, and the actual case summaries. A table of cases and an alphabetical index are also included to help locate specific cases within the text.

We have identified and summarized cases involving HIV or AIDS as of June 1, 1989. This survey includes decided, settled, pending, and filed cases at the Federal, State, and local levels. It includes not only court cases but also complaints filed with State and local human rights commissions and related administrative agencies. (See Methodology section. For a review of legislative trends, see Gostin 1989d.)

reasons. First, undecided cases are generally more recent than decided cases. By summarizing pending cases we enable the reader to observe more recent fact patterns and to monitor trends in the case law. Second, the interest in AIDS litigation is not only with the precedential value of decided cases. We are also interested in the factual disputes that rise to the level that provokes a formal legal complaint. These fact patterns can often illuminate our understanding of the social impact of the epidemic.

The cases are classified by subject matter under a comprehensive system developed for this project (see Subject Matter Outline). The organizational framework adopted under each subject matter heading is as follows:

1. Decided Court Cases.
2. Court Cases Settled, Jury Verdicts, Dismissals.
3. Complaints Filed in Court.
4. Human Rights Commissions and Other Agencies.

We adopted the convention in the *Uniform System of Citation* (the blue book) by first listing Federal cases, then State cases, and finally municipal cases (each ranked by order of seniority of the court). (See the section on organization of cases.)

The cases and controversies revealed in this survey have, for the most part, barely caught the attention of the legislature and public health communities. Yet they represent the conflict of values, legal principles, and public health policy that are likely to emerge as the major issues of the future, requiring resolution by legislatures, policymakers, and health officials.

The cases show how socially divisive the HIV epidemic has been, and will continue to be. The AIDS cases in this survey operate as a lens revealing the major public policy and social tensions of the epidemic.

This survey, then, should provide a valuable tool in forecasting the major policy and public health issues of tomorrow.

vocacy Systems; the American Public Health Association (APHA); the AIDS Legal Referral Panel of San Francisco; the National Prison Project of the American Civil Liberties Union (ACLU); Whitman Walker Clinic of Washington; AIDS Civil Rights Project of the National Gay Rights Advocates (NGRA); the Pettus Crowe Foundation; the San Francisco and Los Angeles Offices of the American Civil Liberties Union; and the Office of the City Attorney in Los Angeles.

There were several individuals and organizations who graciously gave us access to their case files; provided case illustrations; sent us copies of unpublished or otherwise hard to find documents; advised and guided us to case materials; circulated our survey letter; or otherwise provided us information. We appreciate the help of Ken Labowitz of Young & Goldman; Ben Schatz, NGRA Civil Rights Project; Judy Greenspan, ACLU National Prison Project; David Schulman, Office of the City Attorney, Los Angeles; Clint Hockenberry, AIDS Legal Referral Panel, San Francisco; Mat Coles, ACLU of Northern California; Norm Nickens, San Francisco Human Rights Commission; Ruth Eisenberg, Whitman Walker Clinic; Rich Gilbert, APHA; Jean McGuire, NORA; Irene Crow, Pettus Crowe Foundation; David Piontkowsky, Esq.; Colonel Francis Gilligan, Army Office of the Judge Advocate General; Major Paul Capofari, Army Office of the Judge Advocate General; Tom Heintzelman, Army Office of the Judge Advocate General; Lt. Siguurd Peterson, Navy Office of the Judge Advocate General; Richard Bollow, of Jenner & Block; and Rita Theisen of LeBoeuf, Lamb, Leiby & MacRae.

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We especially acknowledge the staff at the National AIDS Program Office (NAPO) and other offices of the Public Health Service (PHS) in the Department of Health and Human Services: Jim Allen, Director, NAPO; Iris Gelberg, External Relations Officer and Project Officer, NAPO; Richard Riseberg, Associate General Counsel, Public Health Division; John Wells, NAPO; John Fanning, Senior Health Policy Adviser, Health Planning and Evaluation, PHS; Christopher Pascal, Branch Chief, Public Health Division, Alcohol, Drug Abuse, and Mental Health Administration; and Patricia MacKey, Office of Civil Rights. These individuals provided critically important advice at every stage of the project.

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as attorneys who represented parties. Other sources were parties to litigation. There were some central repositories of litigation materials collected from many other sources throughout the country. There were many individuals who simply referred us to cases.

We used five collection methods: (1) a survey letter; (2) onsite research of case files and personal interviews; (3) reference to annual reports and other summary documents; (4) review of commercial reporting publications, newspapers, and other periodicals; (5) computerized legal research.

The case materials actually received include copies of decided cases (e.g., opinions, summary judgments, orders), administrative agency decisions (e.g., human rights commissions), case illustrations, and case commentaries.

Collection of case materials began in late October 1988 and ended in late June 1989. Two updates of the AIDS Litigation Project will be completed for the National AIDS Program Office in 1990.

1. Survey

The survey letter asked for copies of court decisions, or citations, or filed papers in both decided and pending cases in all areas of civilian and military law relating to the human immunodeficiency virus (HIV).

The survey letter was sent to approximately 350 organizations or individuals throughout the country. These organizations included the members of the National Organizations Responding to AIDS (NORA), selected State public health officials, associations such as the American Bar Association and the American Medical Association, the military Office of the Judge Advocate General, civil rights groups, public interest law firms, and individual attorneys—some in general practice and some in specialty AIDS law practice.

Approximately 45 written responses to the survey letter were received. The types of responses included copies of case materials, references to other sources of cases, or that no cases were initiated or collected by the organization surveyed.

several locations.

Early in the survey we realized there were organizations and individuals who would have initiated litigation or collected cases on AIDS. We asked and received permission to go through the case files of several of these organizations for our survey purposes.

During the period November 1988 to June 1989, onsite case file reviews and personal interviews were conducted in New York City, San Francisco, and Washington, D.C. Litigators worked in a variety of settings, including private practice, the military office of the judge advocate generals, public interest law firms, professional associations, and government service.

American Civil Liberties Union

The ACLU files contain more than their own litigation. Their files contain clippings and reports of cases sent to them, not only by their own affiliates and chapters, but also by other organizations. We reviewed approximately 80 cases, of which 77 were selected. The ACLU search was done in June 1989.

LAMBDA Legal Defense Fund

We reviewed the files of AIDS litigation materials at LAMBDA in January and February 1989. Like the ACLU, LAMBDA's files contain far more than their own litigation. They, too, collect information and cases from other organizations. We reviewed approximately 70 case files, of which 65 were selected.

Columbia University AIDS Law Clinic

The review of case files of the Columbia University School of Law AIDS Law Clinic was done in March 1989. In the 7 months of the clinic's existence, it had handled 26 cases, of which 22 were selected.

National Gay Rights Advocates (NGRA)

Review of the case files at NGRA in San Francisco was accomplished in December 1988. Similar to other advocacy groups, the NGRA files contained case materials, correspondence, and other documents sent to them from other sources, as well as many NGRA-generated cases.

3. Annual Reports and Summary Documents

Reference was made to annual reports and other documents prepared by organizations deciding or litigating AIDS cases. Such documents often provided useful brief illustrations of cases in a variety of topical areas, such as discrimination, commercial, or criminal law. In many of the administrative law areas (e.g., human rights commissions), cases handled were typical and thus a brief summary characterization of them is included in the survey.

In addition to published and unpublished reports, we also conducted personal interviews with counsel to each organization. Counsel furnished us with updated statistics and case illustrations.

The following organizations provided assistance: New York City Human Rights Commission, San Francisco Human Rights Commission, San Francisco AIDS Legal Referral Panel, Los Angeles Office of the City Attorney, and the Office of Civil Rights of the U.S. Department of Health and Human Services.

4. Commercial Reporting Services, Newspapers, and Periodicals

When necessary, because the original source document was not readily or actually available, reference was made to commercial reporting service sources or to newspapers or other periodicals.

By far the most valuable secondary source was the *AIDS Litigation Reporter* (ALR) published by Andrews Publications. We reviewed the entire series of

ports all of the highest level State courts for each State, but only some of the lower level courts for some of the States.

We also conducted less comprehensive searches on LEXIS, a database that is comparable to WESTLAW. Most importantly, we Shepardized most case cites in the survey in June 1989. Shepardizing is a technique that generates the most up-to-date cite for court cases and indicates whether other courts have cited that case.

Case Selection Criteria

Cases were selected if they dealt with HIV issues in more than a minimal way. For instance, in a number of cases, AIDS or HIV was mentioned in a footnote and the remainder of the case was about another type of infection. These cases were rejected. Similarly, if the litigation dealt with AIDS or HIV but the court's ruling or the litigation dealt only with technical legal procedure, such as a motion to transfer a case from the Federal court to the State court, such cases were also rejected. Where, however, procedural issues had a direct effect on the outcome of the litigation, such as the determination of the time from which the statute of limitations would run, such cases were included.

Cases were read, evaluated, summarized, and then classified according to subject matter. Often cases raised several important issues and a subjective choice was made as to where it would be classified in the subject matter outline.

this relatively early stage of judicial involvement in the HIV epidemic.

I. AIDS Education

Numerous States have authorized and funded AIDS education in schools (Gostin 1989d). In some of these States the language of the statute or regulation appears to make attendance in school AIDS education programs mandatory (although some statutes or regulations specifically allow a parent to withdraw his or her child from attendance). In *Ware v. Valley Street High School District*, a strict religious group asked for its children to be exempt from required AIDS education under New York law. The group members claimed that the required exposure to ideas they regarded as immoral violated their constitutional right to free expression and privacy. A New York appellate court issued a temporary injunction compelling the education authorities to exempt the children.

Other statutes address the content of AIDS education. The Federal Helms amendment prohibits Federal funds from being used to provide AIDS education activities that "promote or encourage, directly, homosexual activities." Several States have enacted statutes based upon the Helms amendment. The *Gay Men's Health Crisis v. Bowen* challenges the constitutionality of the Helms amendment because it inhibits the ability of the group to produce federally funded AIDS prevention materials that are medically accurate and effective.

II. Protection of the Blood Supply

By the summer of 1982, just a year after the first cases of a disease that became known as AIDS were identified, *Pneumocystis carinii* pneumonia was reported in three hemophilia patients (Centers for Disease Control 1982a). This confirmed suspicions that AIDS was probably transmissible through an infectious blood-borne agent. Transfusion-related cases reported in December 1982 (CDC 1982b) brought into question the safety of the national blood supply (Neslund, Matthews, and Curran 1987).

By March 1983, the CDC issued guidelines recommending that blood collection centers ask a series of questions of prospective donors and tell them to refrain from giving blood if they are in a high-risk group. Similar guidelines were published directly

By early 1985, a test (ELISA) to detect antibody to HIV was commercially available, and the CDC recommended its use in screening the blood supply (CDC 1985). Federal regulations and many State statutes now require the screening of all blood and tissue products that are to be used in human beings (Gostin 1989d).

Much of the current litigation concerning the transfusion of HIV-contaminated blood or blood products arose during the period of uncertainty between late 1982 and early 1985.

A. Standards of Negligence and Strict Liability for Blood Transfusions

Two broad claims have been made to establish liability for transfusion of HIV-contaminated blood. The first claim is under a standard of negligence that requires the plaintiff to prove that the blood bank or health care provider failed to protect the blood supply using a method that was below the general standard of care employed in the industry at the time. This could involve a failure to take the necessary steps to determine which donors were in high-risk groups and then to advise them not to give blood (self-deferral); or a failure to satisfactorily screen the blood for HIV.

The second claim is under a theory of strict liability. Strict liability, under many State statutes and common law, is often applied to the manufacturer of defective products. If this standard applies, the defendant will be liable even if the care and practices observed were as good as those prevailing in the industry at the time.

The key question in most blood transfusion cases, then, is whether a standard of negligence or strict liability will be used by the courts. The clear trend is to use a standard of negligence, not strict liability (e.g., *Kirkendall v. Harbor Insurance Co., Coffee v. Cutter Biological, Jones v. Miles Laboratories, Poole v. Alpha Therapeutic Corp., Shelby v. St. Luke's Episcopal Hospital,* and *Kozup v. Georgetown University*).

State statutes that shield blood collection agencies and health care providers from strict liability have been found constitutional in at least three States (*McKee v. Cutter Laboratories, Hyland Therapeutics v. Superior Court,* and *Samson v. Greenville Hospital System*). One court, however, construed its blood shield statute so narrowly that a blood collection

ated issue is whether a State law limiting dam-
medical malpractice applies to damages
l against blood suppliers. At least two States
held (*Sloan v. Central Indiana Regianal Blood*
and *Dale v. Irwin Memarial Blaad Bank*).

od Donor Confidentiality: Discovery of ood Donor's Identity

iffs, in pursuing an HIV-related case, may
discover the identity of blood donor(s). There
numerous reasons for seeking discovery. If the
volves negligence of a blood collection
or provider, the plaintiff may be interested in
vhether the defendant took reasonable care in
juestions for the purposes of self-deferral. Or,
ntiff in a car accident may be seeking addi-
amages for contracting HIV. In order to
nat he contracted HIV from a blood trans-
he plaintiff may want to know if the donor
V-seropositive.

laims for discovery by plaintiffs purport to be
y for the administration of justice. However,
ther side, blood collection agencies are reluc-
disclose this information. They claim that the
and details relating to the donor should be
confidential for two reasons: first, to protect
acy of the donor and the integrity of the
n/patient relationship; and second, to encour-
le to voluntarily give blood. There is a con-
t persons would be less willing to give their
their identity might be revealed at some later

policy issues are being balanced in the courts
any clear trend emerging. The plaintiff's in-
the administration of justice is articulated by
s Supreme Court in *Tarrant Caunty Hospital*
Hughes. The reasons are that the donor's
did not fall within the statutorily protected
n/patient privilege, since the blood was not
a physician; that the donor's right to privacy
compelling; and that the volunteer blood
vas not unreasonably harmed.
lood bank's position favoring confidentiality
's is articulated by the Florida Supreme Court
ussen v. South Flarida Blood Service. The court
hat the personal interest in privacy and the
issues in promoting a volunteer blood supply

of Hopkins County and *Belle Bonfils Memorial Blood Center v. District Caurt*).

C. Directed Donations

Even where a blood supplier has exercised due care in screening its blood products and donors, there remains a small chance of receiving HIV-contaminated blood. Unable to recover under a product liability claim, it is possible that the infected patient will turn to other claims for relief. One such claim is based on the failure to warn the patient about the risk of HIV associated with transfusion (e.g., *Huskey v. Cutter Graup Praducts* and *Ray v. Cutter Labaratories*). A second claim is that the person should have been informed of alternatives to general transfusion such as directed or autologous donations.

These two complaints have also been raised against hospitals or physicians for failure to disclose risks or alternatives as a prelude to obtaining consent for a blood transfusion. Such a case is pending in *Dae v. Jahnstan* and *Dae v. Werner*. In the unreported case of *Osborn v. Irwin Memarial Blaad Bank* No. 981642, (Cal. Super. Ct. S.F., December 1, 1988), the jury awarded substantial damages in part because the provider discouraged a designated donation.

In *Kazup v. Geargetown University* the parents of a child who received an HIV-contaminated transfusion raised both such claims against the blood supplier and the hospital. The court rejected them both, holding that the risk of HIV infection was not a material fact, given the state of knowledge at the time, 1983, when it was believed that the risk of HIV from transfusion was 1 in 3.5 million. Changes in public perception of both the probability and the gravity of the risk from transfusion may affect the outcome of future cases.

D. Duty To Inform Recipients of Contaminated Blood

Most blood banks and hospitals have a "look back" program, which is designed to inform recipients that they have been transfused with tainted blood. The plaintiff in *Kobey v. Alvarada Hospital* claimed that he was not informed soon enough, thereby causing a delay in medical treatment. The case has yet to be resolved. However, as early treatment interventions are developed, this kind of case is likely to occur more frequently.

One reason for this is that most States do not classify HIV as a sexually transmitted disease (STD). Such a classification in most States would trigger the reporting requirements under the State public health statute.

In the two large seroprevalence States, court cases were filed by physicians' associations to compel the public health departments to designate HIV as an STD, and thereby put into effect the States' reporting and testing regulations for STD's.

In the California case, the plaintiffs withdrew their suit. In New York, the court held that the classification of diseases is within the sole discretion of the public health commissioner unless he or she acts in an arbitrary or capricious manner. In this case, the evidence supported the commissioner's decision not to so designate the disease (*NY State Society of Surgeons v. Axelrod*).

B. Testing/Screening

1. Informed consent

The issue of whether health care providers, employers, insurers, or others can test a person without his or her knowledge or consent is highly controversial (Gostin 1989b). Health care providers have traditionally gotten consent for the drawing of blood, but not necessarily for each and every test performed on the blood. The question for the courts to resolve is whether the law requires specific informed consent for HIV tests. The two areas of law that are relevant are the common law doctrine of informed consent and more recent HIV-specific consent statutes.

Many of the more interesting cases are filed but are yet to be decided. These cases usually concern not only testing and informed consent, but also unauthorized disclosure of confidential information. See, e.g., *Doe v. Maccabees Mutual Life* (HIV test performed by insurance company despite express refusal by applicant); *Doe v. Dyer-Goode* (physician tested for HIV for the purpose of marital application even though only a syphilis test was required by law); *Doe v. Conly* (unauthorized HIV test result while being treated for diabetes); *Doe v. Wills Eye Hospital* (HIV test on patient without consent or counseling); *Doe v. Trident Cruise Services* (employee tested during employment physical without consent). Two cases, *Conly* and *Wills Eye Hospital*, include a count of negligent medical

2. Constitutional search and seizure

The fourth amendment to the Constitution prohibits the State from carrying out unreasonable searches and seizures. The courts, including the U.S. Supreme Court, have been quite clear that a blood test is a search within the meaning of the fourth amendment; see, e.g., *National Treasury Employees Union v. Von Raab*, 109 S. Ct. 1384 (1989). The major question is whether the searches are "reasonable."

Two Federal courts have held that State or municipal testing programs potentially violate the fourth amendment. The case of *Glover v. Eastern Nebraska Community Office of Retardation* is discussed in the section on health care discrimination. In *Glover* the eighth circuit court of appeals held that a testing requirement for health care workers at a mental retardation facility violated the workers' fourth amendment rights because of the minimal risk of transmission. The court in *Anonymous Fireman v. City of Willoughby* similarly found a fourth amendment violation when the city ordered all its fire fighters to be tested for HIV.

The critical issue under the fourth amendment for future cases will be whether the State can demonstrate a significant risk of transmission and that testing is a reasonable public health measure to reduce that risk.

The courts have upheld Federal screening programs both on constitutional and statutory grounds. In *Local 1812, Amer. Fed. of Gov't. Employees v. U.S.*, employees challenged the State Department's mandatory program of screening of employees seeking service abroad. The court decided that the epidemiologic fact of lack of transmission from casual contact was not the predominant issue. It said the purpose of the State Department program was not to avoid contagion. Rather, the purpose was to ensure that foreign service employees were not exposed to opportunistic infections while posted abroad. The State Department was also concerned with maintaining a positive image of America abroad. That image could have been tarnished if it became known that some of its employees were HIV positive.

In *Batten v. Lehman*, a Federal district court refused to grant a temporary injunction to prevent the Navy from continuing its program of screening and excluding HIV-positive short-term active duty personnel from the service.

transmitting HIV is a criminal offense in itself or whether it is relevant to the charge. We expected to find three kinds of cases: (1) those based upon the traditional criminal law, (2) those based upon older public health (STD) offenses, and (3) those based upon newer AIDS-specific statutes. Our survey did not reveal many public health or AIDS-specific offenses. A key issue in public health offenses is whether HIV should be classified as a sexually transmitted disease. In most States it is not classified as an STD. In *State of Connecticut v. Volpe*, for example, the prosecution asked the court to order an HIV test pursuant to its venereal disease statute. The court held that the defendant could not be tested because HIV is not a venereal disease under the Connecticut statute.

The survey did not reveal any cases under AIDS-specific statutes. Perhaps the reason for this is that many of the AIDS-specific offenses are very recently enacted. Future trends may involve increased use of these statutes.

The survey did uncover prosecutions under the traditional criminal law. We estimate that there have been over 100 criminal prosecutions alleging risk of transmission of HIV. However, the traditional criminal law cases illustrate the difficulty of proving an intent to kill someone through viral transmission. In cases such as *State of Florida v. Sherouse*, *People v. Markowitz*, and *State of Indiana v. Haines*, prosecutors could not sustain a charge where they were required to prove the accused intended to kill or cause serious harm through viral transmission.

In the future it may well be easier to sustain a charge based upon reckless endangerment as in *State v. Beason*, even though that case was unsuccessful because of the reluctance of a witness to testify.

U.S. v. Moore raises a fascinating issue as to whether the mouth and teeth of an HIV-infected person can be regarded as a "dangerous" or "deadly" weapon. The court found that it could be such a weapon. Much evidence was presented (some inaccurate) about transmission of HIV through a bite. It is difficult to tell from the court's decision whether the case would have been decided the same way if the defendant were not seropositive.

The cases we uncovered are only a small fraction of the total number that have reached at least the indictment stage. The great majority of these cases

logic status can prejudice the fairness of the trial. A number of cases are reported in this survey that allege that knowledge of, or publicity relating to, a defendant's serologic status (or even his or her association with a seropositive person) made it impossible to get a fair trial. These cases include allegations of prejudice by the grand jury (e.g., *People v. Hawkrigg*), the jury (e.g., *Commonwealth of Pennsylvania v. Newman* and *State v. Mercer*), or the judge in sentencing (*People v. George*). In each of these cases the court held that the defendant was not denied a fair trial because the error was harmless. Each case was decided on its facts. It is conceivable that in an egregious case the court would hold that the error harmed the defendant and that he or she was denied a fair trial.

C. Compulsory Testing of Criminal Defendants

The third issue raised involves the HIV testing of defendants involved in violent crime, particularly if the crime was related to sex or drug use. Many State statutes have been recently enacted authorizing or requiring testing (Gostin, 1989a). Our survey revealed a few cases relating to those new statutes (e.g., *Rice v. Palo Alto Municipal Court*). It also uncovered cases where judges ordered testing under their own inherent powers or pursuant to statutes not specifically relating to HIV.

Barlow v. Superior Court has illustrated that, even in the absence of an HIV-specific statute, courts may be prepared to compel testing and to disclose a defendant's serologic status. *People v. Thomas*, reviewed in the case summaries section on prisons, also supports testing. In that case a convicted rapist was required to be tested, and the results disclosed to the victim and to prison officials. The court observed that the U.S. Senate had recently approved in a vote of 97–0 a provision that would require anyone convicted of a serious crime related to sex or intravenous (IV) drug use to be tested. The court noted that the "equities of this entire situation" require testing (see also, e.g., *Johnson v. Municipal Court, San Francisco*).

D. Sentencing of HIV-Positive Offenders

The fourth issue surveyed involves the question of whether HIV can be used as an aggravating or mitigating factor in sentencing—i.e., can the court sentence a person more or less harshly solely because he

tempted murder."

A defendant's serious illnesses caused by HIV can also form compassionate grounds for dropping a charge, or for reducing or completely forgoing the sentence. In *People v. Camargo*, the Court dismissed an indictment of a person with AIDS in the interest of justice. The court provided criteria for such a decision and noted that the defendant probably would be dead before he could ever be incarcerated.

Most courts in this survey, however, were not influenced by the fact that a defendant is seropositive or has AIDS. For an appellate court to reduce the sentence of a trial court it must find extraordinary circumstances (e.g., *People v. Marlon Brandow*). Such circumstances are rarely met if the defendant is merely seropositive (e.g., *People v. Chrzanowski*). Even if the defendant has full-blown AIDS, courts have often been unsympathetic (e.g., *State of New Jersey v. Wright*, or *State v. Waymire*). The *Wright* case shows just how unsympathetic some courts are to a defendant with AIDS. There were only 3 months left to run before he could be released on parole without court intervention. The inmate had kicked his drug habit, was active in an anti-drug campaign, and the stress of prison was exacerbating his condition. The court refused to allow early release, arguing that he would have to show a "severe depreciation" in his health caused by the lack of medical services in prison. The court noted that the defendant brought about his illness himself, implying blame.

E. Dismissing the Indictment in the Interests of Justice

In cases where a person with AIDS has a poor prognosis, some courts have allowed the indictment to be dismissed in the "interests of justice" (e.g., *People v. Quinn* and *People v. Hammond*). In *People v. Williams*, the charges were dismissed even though the defendant was an IV drug user and potentially could be a menace to the public health. But he was critically ill and dying from AIDS. The court wrote: "even if a man has not lived with dignity, our society's own self-respect demands that he be permitted to die in dignity." However, the mere fact that a person has AIDS may not be enough to dismiss the indictment (e.g., *People v. Moros*).

publicized case is *City of New York v. St. Mark's Baths*, where the court reviewed the large number of documented cases of high-risk behavior, stating that the public health department was well within its authority to regulate the bathhouses.

Less clear is the impact of adult bookstores or video centers in contributing to the spread of HIV. When the State controls the sale of literature it may implicate not only the right of privacy but also the right to free expression guaranteed under the first amendment. Still, courts have upheld regulation of adult bookstores and video centers where the State action is purported to be to slow the spread of HIV (e.g., *Doe v. City of Minneapolis*).

VI. State Regulation of Products, Consumer Protection, and Fraud

One of the prime roles of government is to protect ill persons from being exploited by sellers making exaggerated or false promises about a cure or palliative for their medical conditions.

The courts in a number of cases have not permitted fraudulent representations, e.g., *People v. Martin and Martin* (hypnosis course for HIV-positive persons); *Complaint by the E.P.A. against Georgia Steel and Chemical Co.* (advertising pesticide as effective against HIV); *Minnesota v. TBA* (home testing kits); *Missouri v. Nave Airway* (resuscitation device promoted to prevent spread of HIV); and *People v. Ancient Gold* (cure for AIDS).

VII. Private Tort Actions

A. Negligence

Liability in tort can occur under several legal theories. Strict liability usually only applies to the manufacture of products, a subject discussed in the section on blood transfusion. Most other cases come under a theory of negligence, e.g., that the health care provider or other person failed to take reasonable care toward a person to whom a duty of care was owed.

There is an ever-increasing number of cases where plaintiffs claim that due to negligence HIV was, or might have been, transmitted. The factual circumstances of these cases are highly diverse. For example, in *Prego v. City of New York*, a physician sus-

Francisco General Hospital, a nurse contracted cytomegalovirus (CMV) from an AIDS patient and passed it on to her husband and child. She claimed the hospital was negligent in failing to provide adequate training and in not requiring nurses to wear gloves or gowns.

Many of the legal issues in these cases are of a technical nature, such as whether the statute of limitations had run. For most courts, the time for the suit begins from the time of discovery of the exposure to HIV, not from the time of transmission (e.g., *Prego v. City of New York* and *DiMarco v. Hudson Valley Blood Services*).

B. The "Right To Know"

Negligence claims sometimes involve a "right to know." Several cases allege that persons potentially exposed to HIV had the right to be informed. This occurred in the case of *Christian v. Sheft*, where the jury found that Rock Hudson was guilty of "outrageous conduct" in failing to inform his sexual partner that he had AIDS. In other cases, a security guard (*Johnson v. West Virginia University Hospital*) and a nurse (*Halverson v. Brand and Cohen*) claimed they had the right to know if they were working with persons who were HIV positive. In *Halverson* (an undecided case) an operating room nurse sued the hospital because she was not informed that a surgical patient was infected with HIV.

In most cases the plaintiff who alleged negligence did not in fact contracted HIV. In such cases the claim was often for negligent infliction of emotional harm.

In *Mosele v. Bures*, however, the court would not even allow a plaintiff to bring a negligence case claiming she was exposed to HIV, unless she was first tested.

C. Infliction of Emotional or Mental Distress

Given the grave prognosis and social stigmatization associated with HIV infection, it is hardly surprising that many complaints include a request for damages for the intentional or negligent infliction of emotional or mental distress. The clearest cases are those where the defendant's conduct has led directly to the plaintiff contracting HIV, as with a careless blood supplier (e.g., *Allen v. Irwin Memorial Blood Bank*). Claims

Surviving spouses have been awarded damages for the loss of consortium against negligent blood suppliers (e.g., *Carroll v. Blood Center of SE Wisconsin* and *C.W. v. Belle Bonfils Blood Center*).

D. Contracts and Wills: AIDS Dementia

HIV disease can affect the neurological system, causing dementia and other cognitive difficulties. There may, therefore, be challenges to a person's competency to make decisions relating to treatment, contracts, and wills. *In Estate of O'Shields*, the testator's will was contested on the ground that he had AIDS dementia. The court found no credible evidence that the testator was mentally incapacitated. The court opined that a rift in the family was a more probable explanation for the litigation.

VIII. The Administration of Justice in the Court System

The American Bar Association has issued guidelines that recommend that no special precautions have to be taken in a courtroom to avoid contagion with HIV. Several courts have reiterated that special precautions usually are not necessary because HIV is not spread through casual contact (*In re Peacock; Wiggins v. Maryland*).

There is also great media interest in court proceedings involving persons with HIV. In *Stenger v. The Morning Call*, the court held that the right to a free press does not extend to having a right of access to pretrial discovery material.

Finally, a person's illnesses as a result of HIV disease may require an expedited trial. In *Murphy v. Community Hospital of the Monterey Peninsula* the court ordered an expedited trial in a civil case where the defendant hospital was deliberately slowing the process in the expectation that the plaintiff would die before the trial.

IX. Family Law: Divorce, Child Custody, Parental Rights, and Paternity

Spouses in marital disputes may try to use the fact that their partner is HIV positive against them. For the most part courts have not allowed this unless the person's infection or disease was directly relevant to

to parent (*Accord, Doe v. Roe*).

Some spouses, either through genuine fear for their child's health or through vindictiveness, even seek to terminate their former partner's parental rights. This would take away the right to visit the child. In *Stewart v. Stewart*, two doctors testified that if the husband cut his finger while extracting one of his child's baby teeth he could transmit HIV. The trial court terminated his parental rights on the grounds that "even if there was a 1 percent chance" of contracting HIV it was unacceptable. The appellate court overruled, saying that the risk was too small to remove such a fundamental human right as parenthood. (See also *Wallace v. Wallace* and *Jane W. v. John W.* "untimely diaper change" does not support a ruling that a father with AIDS must have supervised visits).

The court in *Roe v. Doe* similarly held that the mere diagnosis of AIDS dementia should not prevent a husband from having joint physical custody of his son.

Not all courts, however, regard the father's sexual orientation or serologic status as irrelevant. In *Crawford v. Crawford* the court ordered restrictions on the father's visitation privileges to prohibit the presence of any homosexual during visits. The father was also ordered to inform his ex-wife of any results of an HIV test. However, the ex-wife's request that the father's male roommate also be forced to disclose his HIV status was rejected.

Some spouses, frightened of a bisexual spouse, even claim damages for "AIDS-phobia." In *Doe v. Doe* (*N.Y.*) the wife was not permitted to be compensated for emotional distress without proof that she had actually contracted HIV.

The fear of AIDS was also illustrated in *Albany Co. Dept. of Social Services and M., on Behalf of S. v. R.* During paternity proceedings in these two separate cases, the putative fathers refused to undergo blood tests for fear that the needlestick would allow them to be exposed to HIV at work where they were corrections officers. The court rejected this claim.

X. Confidentiality

Concerns about maintaining the confidentiality of HIV-related information have been a constant theme in the cases throughout this survey. Issues of confidentiality can be found in many sections of this

The public interest in the contemporary HIV epidemic is enhanced by the fascination with sexuality, drug use, and blood, the three forms of transmission of the AIDS virus.

Persons with HIV have a powerful interest in maintaining the confidentiality of their serologic or disease status for the same reasons that the public wants to know. Disclosure of this deeply private information tells their family, friends, neighbors, and employers something about their life that is highly personal and intimate. It also may trigger irrational fears of HIV, resulting in their ostracism and exclusion from ordinary life.

There are powerful conflicts between the principles of confidentiality and the "right to know," which the courts have to balance carefully.

A. The Media

The media have suggested that the public has an interest in knowing who has an infectious condition. The public cannot claim that it is actually protected by the widespread dissemination of a person's HIV status. Yet the media do sometimes claim a right to medical data. The Federal freedom of information law provides no basis for a right of access to otherwise confidential medical data (FOI exemption 6). But the right of access to death certificates may be allowed. The media also claim the right to publish this information under the constitutional principle of freedom of expression. There have been innumerable media reports about AIDS, sometimes hurtfully identifying persons infected with the virus.

Court decisions regarding the media's right to receive and publish information identifying a person as having AIDS appear inconsistent. Several courts have protected personal privacy over freedom of expression, particularly where the information was disclosed within the confines of a physician/patient relationship. In *Anderson v. Strong Memorial Hospital*, an AIDS clinic gave a reporter permission to photograph a patient on condition that the patient was not recognizable. When the photograph appeared, friends recognized the patient. The court held that the publication of a recognizable photograph without the patient's permission violated the physician/patient privilege. The court concluded that, in the case of HIV, the physician/patient privilege is critical to encouraging

of Health denied the newspaper's request because it had no "proper purpose" other than "idle curiosity." The court, however, granted access to the death certificate under the freedom of information statute, saying that a decedent had no recognizable interest in privacy. It also held that the "proper purpose" was the public's right to be informed of the reality of AIDS in its own community.

The court in *Yeste v. Miami Herald Pub. Co.* came a quite different decision. The court refused to allow the *Miami Herald* to gain access to the medical records and death certificate of a urologist who was rumored to have died of AIDS. The court said the newspaper had no "direct and tangible" interest in it. The British courts have also ruled that "the public interest in the freedom of the press and informed debate on AIDS was outweighed by the public interest in maintaining the confidentiality of actual or perceived AIDS sufferers." (see *X. v. Y., The Lancet,* Nov. 21, 1987, pp. 1221–1222 [a physician with AIDS]).

In *Lindzy v. South Bend Tribune*, the parents sent an obituary to a local newspaper that did not contain the fact that the son died of AIDS. The newspaper printed an obituary that included that information. The court determined that the newspaper's freedom to print outweighed any privacy considerations.

3. Unauthorized Disclosure

The *Anderson v. Strong Memorial Hospital* case indicated that the courts will be much more likely to safeguard confidentiality of information imparted within the context of a physician/patient relationship. The cases described in this section confirm the importance of confidentiality in health care settings.

The court in *Kautz v. Orizondo* held that the physician must maintain the confidentiality of his patient's HIV status because a fiduciary duty existed between doctor and patient.

An interesting question, yet to be definitively decided, is the extent to which courts will remedy breaches of confidentiality by other health care professionals or other hospital employees. The expectation of privacy in such cases is, arguably, just as strong as in a physician/patient relationship. In *Doe v. Westchester County Medical Center*, a nurse disclosed a patient's HIV-positive test result to his employer (the plaintiff was a pharmacist). The court described AIDS, and proceeded to question the patient about his personal life. The pastor then went to the nurses' station to announce that the patient had AIDS. In fact, he had hepatitis, not AIDS. Subsequently the patient experienced worsening of his ulcer related to distress and questioning by his circle of friends about AIDS.

Many of the cases in this survey involved employers who disclosed intimate health care information about their employees. Many of these employers were health care providers. See, e.g., *Auon v. Baughman* (physician was occupationally exposed to HIV, and hospital disclosed the information to others) and *Doe v. Washington University* (dental program breached confidentiality of student).

The courts also have to decide whether breaches of confidentiality outside of the health care context are actionable. In *Doe v. Borough of Barrington*, the police told the plaintiff's neighbor she should wash with disinfectant if she had touched him. This neighbor then erroneously disclosed to the school board that the children were also infected. The family suffered from the disclosure in that the children were shunned at school, the landlord refused to provide maintenance services, and other parents threatened to boycott the school.

This case powerfully illustrates the interconnectedness of breaches of confidentiality and subsequent discrimination. See also *Morales v. Vasiliadis* (lawyer disclosed to the court that the defendant was HIV positive after being sentenced); *Doe v. City of Cleveland* (police disclosed the fact that plaintiff had AIDS despite a letter stating *"Please,* I trust you will keep this information confidential"); *Huse v. Sims* (roommate ruined a physician's 12-year pediatric practice when he told people the physician tested positive for HIV); and *Urbaniak v. Newton* (disclosure of seropositivity by company's physician).

C. The "Right To Know"

Protection of confidentiality is both a legal and ethical duty. However, in the case of an infectious condition, the consequence of an absolute duty of confidence is that persons who are not informed of the risk may be endangered.

There is increasing demand for a "right to know" the HIV status of persons. State statutes provide some

tions on criminal law and prisons).

In cases where the person can demonstrate a clear risk, the courts have usually been prepared to allow disclosure. In *Tradup v. Mayer*, the court allowed disclosure to a woman who was 9 weeks pregnant by her sexual partner. A more difficult factual case is pending in *Doe v. Prime Health* where an estranged wife is seeking the information. The plaintiff argues he has been separated from and has not had sexual intercourse with his wife for 2 years.

XI. Discrimination

This section examines cases of discrimination against persons infected with HIV that are being litigated across the country in courts and administrative hearings and before human rights commissions. We have counted 139 cases of discrimination decided, settled, or pending in the Federal and State courts. We also reviewed numerous cases of discrimination before human rights commissions and administrative bodies. Our search for human rights commission cases was focused primarily in New York City, Los Angeles, and San Francisco. We believe, therefore, that the number of human rights commission cases we reviewed is only a small fraction of the total national number. Moreover, these cases, which have resulted in a formal complaint, provide only a sample of the kinds of discriminatory practices against persons infected with HIV.

We divide the discrimination cases into several areas, reflecting the diversity of circumstances where HIV-infected persons are treated unequally: education, employment, housing and property, health care, business and commercial establishments.

There is a strong consensus in the courts that if an HIV-infected person is able to participate fully in life activities and there is no significant risk of viral transmission, discrimination is unlawful.

The cases surveyed provide a snapshot of public attitudes and treatment of persons perceived to be, or actually, infected with HIV. It is difficult to understand the legal opinions of courts and administrative agencies without first reviewing the statutory framework.

Statutory protection against discrimination within the public and private sector did not emerge until quite recently. The extant statutory protection of persons with communicable disease is primarily based

For many years there was no clear decision that the act actually applied to communicable disease. As recently as 1986, the U.S. Justice Department concluded that discrimination based upon the fear of contagion was not covered by the statute (Cooper 1986). Today, however, there is little doubt that the 1973 act applies to persons with communicable disease as well as to carriers or even persons perceived to be infected.

The Supreme Court decision in *School Board of Nassau County v. Arline* 107 S. Ct. 1123 (1987) made clear that a person with a contagious disease (in this case, tuberculosis) was a handicapped person within the meaning of section 504. The Court said that a person was "otherwise qualified" for employment if he or she did not pose a significant risk of communicating the disease to others in the workplace or reasonable accommodation could eliminate the risk. The Court adopted American Medical Association (AMA) guidelines in determining whether a person is "otherwise qualified," including: the nature of the risk (how the infection is transmitted), the duration of the risk (how long the carrier is infectious), the severity of the risk (what the potential harm is to third parties), and the probability the infection will be transmitted and will cause harm.

A 1988 amendment to section 504, enacted as part of the "Grove City" Civil Rights Restoration Act, was intended to codify the *Arline* decision. Yet, it is framed not as an entitlement to nondiscriminatory treatment for persons with an infectious condition, but as a limitation. The 1988 amendment states that section 504 "does not include . . . an individual who has a currently contagious disease or infection [who would] constitute a direct threat to the health or safety of other individuals or who, by reason of the currently contagious disease or infection, is unable to perform the duties of the job."

The Justice Department has advised that section 504 applies to discrimination against infected persons, whether or not they are symptomatic or whether it is based upon the fear of contagion (Kmiec 1988).

This survey includes the decisions of several Federal courts that have used section 504 to prohibit discrimination against infected persons by employers or schools (e.g., *Chalk v. U.S. District Court of California, Orange County Supt. of Schools, Doe v. Centinela Hospital,* and *Ray v. School District of DeSoto County*).

gainst infected persons. This statute is too recent for to have identified cases that rely on it.

At the time of writing, the Americans with Disabilies Act was about to be enacted by Congress to prode protection in other areas of the private sector, ch as employment, accommodations, restaurants, d stores.

All 50 States and the District of Columbia have ndicap statutes similar to the Federal Rehabilitation ct. In all jurisdictions except five, handicap statutes ohibit discrimination against private as well as ublic employees (Gostin 1989d). Our survey summazes numerous cases where State courts and human ghts commissions have declared that handicap laws pply to AIDS or HIV infection (e.g., *Shuttleworth v. roward County* and *Cronan v. New England Telephone o.*). There are many more informal opinions, for xample, by State attorneys general, making the same oint.

To underscore the importance of protecting persons ith HIV infection from discrimination, several States nd municipalities have enacted AIDS-specific statutes or ordinances. State antidiscrimination statutes aracteristically target specific areas, such as mployment, housing, or insurance. Municipal ordiances, such as in San Francisco and Los Angeles, re more comprehensive in prohibiting discrimination business establishments, public accommodations, ducational institutions, and city facilities or services.

The cases that follow show that many, but not all, iscriminatory practices can be litigated under existg law.

. *Education*

From the earliest times of the HIV epidemic, exclusion of children infected with HIV from school was n issue debated with great emotion. For many par- seemed inconceivable that children with HIV e allowed to attend school.

entatives for the handicapped, however, had chieved the legislative goal of ensuring full- handicapped children. The Fedlar State statutes, as nation against the infected with Act, represent- upon the Fedhildren Act their ability to learn or do the required classroom work. As learning and behavioral problems are not necessarily the result of HIV disease, the EAHCA is usually not applicable in the absence of other handicaps. This has advantages for HIV-infected students, since they do not have to exhaust their remedies under the EAHCA, but can go directly to Federal court under the Rehabilitation Act (e.g., *Robertson v. Granite City Community Unit School District No. 9*).

The U.S. Court of Appeals for the Eleventh Circuit in *Martinez v. School Board of Hillsborough County* was presented with a case in which both Federal statutes applied. The child was mentally handicapped and, therefore, subject to the EAHCA. She also had AIDS, providing her with protection under the Rehabilitation Act. The court found that there must first be a determination of the child's appropriate educational placement under EAHCA procedures. The next determination is whether she is otherwise qualified to participate in that placement under the Rehabilitation Act. If she is not otherwise qualified, it is necessary to decide whether the school can provide reasonable accommodations to allow her to participate in the least restrictive, most appropriate placement.

Most of the cases in this survey were decided solely under the Rehabilitation Act or comparable State handicap statutes. There are also State and local statutes that specifically prohibit discrimination against persons infected, or appearing to be infected, with HIV. These newer statutes are likely to provide the basis for the next generation of litigation.

The approach of the courts under the Rehabilitation Act and similar State handicap statutes has been to require school boards to fully integrate the HIV-infected child into the ordinary classroom (e.g., *Ray v. School District of DeSoto County, Doe v. Dolton Elementary School District No. 148,* and *Robertson v. Granite*). This desire to integrate HIV-infected children was even applied in a case of a kindergartner who bit another child and who was labeled as "aggressive" by the school psychologist (*Thomas v. Atascadero United School District*).

These courts have found that AIDS and HIV are protected handicaps within the meaning of the Rehabilitation Act and comparable State statutes; and that infected children are otherwise qualified to attend ordinary schools. Many courts emphasize the epi-

stringent compliance with CDC guidelines that all sores and lesions be covered; frequent medical examinations; avoidance of contact sports; disclosure of the infected pupil's medical condition to faculty and staff; and AIDS education for the infected children, the parents and sometimes the faculty and other pupils (e.g., *Ray v. DeSoto, Thomas v. Atascadero,* and *Doe v. Dolton).*

In cases where there may be some behavioral or medical reason not to fully integrate the child, some courts lay down a fair procedure for deciding the case that includes parental and medical participation (*N.Y. v. Dow*).

These courts required full integration without any visible barrier between the child and his or her classmates. To do otherwise, the courts reasoned, would cause irreparable emotional and psychological harm to the child (e.g., *Robertson v. Granite*). However, the court in *Martinez v. Hillsborough*, while ruling in favor of the infected child, laid down a "safeguard" that much more clearly singled the child out as potentially contagious. That court required the child to sit in a cubicle in the classroom where she could observe and hear the discussion. The cubicle, to be sure, allows the child to be in the classroom and avoids the remote risk of transmission. However, it provides a visible symbol of separation of the child from the rest of the class.

The most difficult cases involve decisions to exclude students from educational settings where they may be inherently more likely to cut themselves and expose others to HIV. These cases include a dental student who was excluded because the school program involved invasive procedures such as tooth extractions (*Doe v. Washington University Dental School*), and a student enrolled in a program of training to become a medical assistant (*Doe v. National Education Center and Strayer*). The *Washington University* case is pending and the *Strayer* case is settled, so there is no clear indication on which way the courts will go.

There have also been a number of cases upholding the right of teachers infected with HIV to continue to work (e.g., *Chalk v. U.S. District Court of California,* which is reviewed in the section dealing with employment).

workers. When an employee develops HIV-related symptoms or even full-blown AIDS, it does not necessarily mean that he or she is incapable of working. The nature of HIV disease is that it is cyclical, involving bouts of illness and physical incapacity. At other times the person may be capable of normal work. If the employer provides reasonable accommodations that allow, for example, for periods of absence, persons with AIDS often will want to, and are capable of, work.

The kinds of employment complaints reviewed in the survey are quite wide. Many of the cases are still undecided so that the facts are not proved. Still, the wide range of complaints provides some insight into the kinds of employment disputes that have occurred since the start of the HIV epidemic. Examples of adverse employment actions complained of are as follows:

- Employers terminated persons with HIV without requesting medical evidence, holding a hearing, or providing a trial period to determine competency (e.g., *Laredo v. S.W. Community Health Services, Raytheon Company v. Fair Employment and Housing Commission, re Estate of Chadbourne,* and *Shuttleworth v. Broward County).*
- Employers moved employees to menial positions, such as an experienced teacher to an administrative position (*Chalk v. U.S. District Court of California*) or a firefighter to a janitor (*Severino v. North Fort Myers Fire Control District*).
- Employers altered the employee's insurance benefits to exclude AIDS-related expenses (*McCormick v. Hechnter* and *Doe v. Beaverton Nissan*).
- The employer cut the salary of an HIV-infected person (*Crowley v. Idelman Telemarketing*).
- The employer goaded and harassed the HIV-infected person, driving him from the work force (*Griffin v. Tri-Met Co.*).
- HIV-positive persons were forced out of lucrative partnerships where they had longstanding relationships (*Gordon v. Blanchard*).
- A National Guardsman was given a dishonorable discharge from the service because he was HIV positive and refused a reduction in rank solely because of his serologic status (*Doe v. N.Y. National Guard*).

disclosed the employee's medical condition to his
nily, friends, and fellow employees. The employee
came depressed and suicidal and thereafter spent
riods in psychiatric hospitals and homeless shelters.
In *Cronan v. New England Telephone Co.*, the em-
oyer required Cronan to disclose his medical condi-
n or lose his job. The medical condition was ARC.
spite a promise of confidentiality, the medical
ormation was widely disclosed within the com-
ny. Fellow employees threatened to lynch him if he
rned to work. This occurred despite Cronan's
cellent 12-year history with the company. The com-
ny at that time had no AIDS education activities.
The survey indicated that HIV-infected employees
re terminated in a broad spectrum of activities,
m teachers (*Chalk*) to telephone company workers
ronan), to county employees (*Shuttleworth*), to qual-
control analysts (*Raytheon*), to choreographers
awn v. Legs Company Partnership). Subtle abilities
do complicated or safety-oriented tasks were not
ually an issue. Nonetheless, we identified three areas
t accounted for the majority of disputes: health
e workers (e.g., *Doe v. Attorney General of the U.S.*
d *Galiher v. County of Los Angeles*); those providing
man services to children, including teachers and
ter parents (e.g., *Houseknecht v. White* and *In re*
kholdt); and people working in food service indus-
es (e.g., *Wolfe v. Tidewater Pizza, Farris v. Mariott*
rp., and *Isbell v. Poor Richard's*). See table 3, In the
rganization of Cases" section, which gives the cat-
orical breakdown of cases.

Some employees alleged that they were dismissed
the basis of rumor or innuendo (that the employee
s in a high-rlsk group or positive for HIV) (*Wolfe*
Tidewater Pizza Inc. and *Little v. Bryce and Ran-*
l's Food Market, Inc.) or the perception that he or
e might be infected with HIV because of absences
e to pneumonia or appearance of loss of weight
oe v. Independent Office Machines).

In one case the image of the employer was impor-
t. In *Shannon v. Charter Real Hospital*, the hospital
ed a head nurse after she appeared on a television
ogram advocatlng human rights for persons with
DS.

Employees were also dismissed despite the fact that
ey had been honored for outstandlng work
weetland v. Telecheck) or had "exemplary" work
rformance records (*Doe v. N.Y. National Guard,*

His employer claimed the termination was not based upon discrimination but that it was because his insurance premiums would go way up or that the company might even lose the health insurance it possessed.

The courts, for the most part, have not been prepared to accept discrimination against HIV-infected employees. The leading case since *Arline* is the decision by the ninth circuit court of appeals in *Chalk v. U.S. District Court of California*. That court held that AIDS was a handicap within the meaning of the Federal Rehabilitation Act. More importantly, an AIDS diagnosis does not, without more, preclude a person from being otherwise qualified to perform the job. If an employee with AIDS is capable of doing the job with reasonable accommodations, then discrimination is prohibited. The employment review, moreover, must be based upon reasonable medical judgments. Because HIV is not communicated through casual contact, the threat of viral transmission, unless there is a predictable exposure to blood, will not be a sufficient justification for discrimination. Most lower courts, before and after Chalk, have followed similar reasoning (e.g., *Shuttleworth v. Broward County, Sweetland v. Telecheck, Buler v. Southland Corp, Seven Eleven Stores, Doe v. N.Y. National Guard,* and *Isbell v. Poor Richard's).*

The courts, moreover, required current state-of-the-art medicine. They rejected, for example, the testimony of a prominent hospital physician who argued in favor of excluding an employee from the workplace because of speculation about the future: "We will eventually discover AIDS is transmitted by casual contact" (*Raytheon Company v. Fair Employment and Housing Commission*). In that case the court also rejected the argument that exclusion of the employee was necessary to ensure a safer workplace.

Antidiscrimination principles, moreover, have been extended to cover not only the employer, but also his or her agent (*Chapoton v. Majestic Caterers and Karageorge*).

The most difficult cases for the courts involve the question of whether HIV-infected health care professionals are "otherwise qualified" to continue working when they may expose patients to their blood or body fluid. Some employers have sought to test employees for HIV (see the section on testing), exclude infected employees from the workplace, or change their job assignments (see the section on health care discrimina-

A major trend can be identified from the numerous cases on employment. The early cases, still winding their way through the courts, often involve discriminatory practices by employers based upon prejudice or fears of transmission in the workplace. As CDC and the Occupational Safety and Health Administration (OSHA) guidelines continue to make clear that these fears are groundless, employers appear much less likely to exclude employees from ordinary workplaces. The new wave of cases involve workplace settings where there is likely to be some exposure to blood such as health care settings, laboratories, and forensic examiners.

C. Housing and Property

There were a wide range of complaints alleging discrimination in housing and property. The factual patterns of the complaints are usually related to the denial of the right of an HIV-infected person to rent or buy property. The complaints alleged, *inter alia:*

- Evictions from housing (*Clover Court Realty v. Lombardi*).
- Rescinding a contract to buy, for example, when the prospective purchaser discovered the previous owner died of AIDS. The broker and seller, also reacting to the social taboo of AIDS, failed to disclose the information (*Kleinfield and Kleinfield v. McNally, McNally and Swift Real Estate*).
- Harassment or assault (*Weingarten v. Gruenberg*).

Equal opportunity in the purchase or leasing of housing is an important purpose of handicap law. There is also a public health purpose when the prospective buyer or renter intends to provide housing, medical, or social services for persons infected with HIV. In *Whitman Walker Clinic and Thomas v. Sibay*, for example, a landlord refused to lease premises to be used for a group home for people with AIDS. In a number of other cases, reviewed in the section on health care, professionals were not leased property because they intended to provide services for persons with AIDS (e.g., *Action AIDS v. Dirot Delaware, Whitman Walker Clinic v. Coakley, Barton v. N.Y.C. Commission on Human Rights,* and *Seitzman v. Hudson River Associates*).

Most of the cases in the housing area were based upon State handicap law or in some cases ordinary contract law. The court in *Weingarten v. Gruenberg* volved" in ensuring nondiscrimination.

Several cases alleged housing discrimination against gay men perceived to be, but not actually, infected with HIV (e.g., *Weingarten*). The court in *Poff v. Caro* held that the laws protecting the handicapped were enacted to prevent discrimination. To distinguish between those who are handicapped and those who are merely perceived to be at risk of becoming handicapped would undermine the purpose of the law.

Where courts in this survey applied handicap law to housing discrimination, plaintiffs usually were afforded relief. The availability of effective remedies was less clear in cases where the court applied contract law. In *Whitman Walker Clinic v. Coakley*, for example, the court refused to require a landlord to lease to plaintiffs who were going to run an AIDS clinic. The court examined the issue more under contract law than under antidiscrimination law. It reasoned that the landlord had been "misled" about what the building would be used for, thus voiding the contract.

D. Public Accommodations and Commercial Establishments

Many of the complaints alleging discrimination in public accommodations or commercial establishments revolved around proprietors refusing to serve persons infected with HIV. The complaints surveyed include refusing to serve HIV-positive customers in such diverse settings as a nail salon (e.g., *Tema S. Luft v. The Nail Gallery,* and *People v. Vartoughian*), a funeral home (e.g., *In re Dimicelli*), and a spiritual retreat (e.g., *Gittleson v. Jacumba Foundation*).

Many of the cases in this section are not decided, but should come within the existing legislative framework of handicap law (see, e.g., the cases of *Seitzman, Action AIDS,* and *Sibay* in the section on housing). A new issue raised in *In re Dimicelli* is whether a handicapped person's death removes him or her from the protection of handicap laws. The court held that egregious conduct against a person who died of AIDS, which has no rational basis, is discrimination and can be prosecuted under State handicap law.

E. Health Care

There is a discernible trend in the pattern of health care discrimination cases surveyed. Early in the epi-

id mucous membrane exposure to blood in health
ire settings has created a new set of fears among
ealth care professionals. The epidemic is also shifting
om predominantly gay men to IV drug users who
ecause of their socioeconomic class are traditionally
nderserved in the health care system. Health care
roviders outside of specialized drug treatment facili-
es also are not used to treating this population.

These new circumstances of the epidemic have led
) a different pattern of discrimination complaints
ivolving unequal access to health care and nursing
omes and inadequate treatment; refusal to provide
remises to persons providing health and dental serv-
es to persons infected with HIV; and testing and
mitations placed on the right of infected health care
rofessionals to practice.

. Failure to adequately treat or care for HIV-infected atients

Persons with HIV suffer from a multisystem disease
rocess. Failure to provide adequate treatment or care
ffects not merely their dignity and self-worth, but,
nore important, their health and well-being. Most
ealth care professionals, despite their fears, have
ontinued to provide necessary care and treatment.
There has been no evidence until now of the extent to
which treatment has been withheld. This survey re-
ounts numerous complaints of inadequate and un-
qual treatment across a wide variety of health care
rofessionals and specialties. Patients complained that
hey were denied adequate emergency treatment (e.g.,
Doe v. Howard University and *Johnson v. District of Columbia*); dentistry (e.g., *Hurwitz v. N.Y.C. Commission on Human Rights, B. v. A Dentist,* and *Beardon v. Sutter Place Dental Group);* substance abuse treatment (*Doe v. Centinela Hospital*); laboratory tests (*Stepp v. Review Board of the Indiana Employment Security Division*); treatments for serious allergies (*Doe v. Lankenau Hospital*); treatment for back problems (*Walsh v. Clemanec*); and counseling (*Brogan v. Kimberly Services*).

Some complaints alleged that serious harm may have been caused by discriminatory practices. In *Doe v. Howard University Hospital,* a hospital emergency ward was alleged to have left a despondent and suicidal woman unattended in a single room. The hospital did not place her on the psychiatric ward because of its policy of not placing HIV-positive patients with other patients. In *Doe v. Centinela Hospital,* informed consent under testing and screening), Doe complained that his physician convinced him that he would die if he had an operation at a local hospital and should seek treatment in San Francisco. However, the physician and hospital administrator refused to make a referral to anyone in San Francisco and did not return the patient's calls. The patient hired a lawyer, and within a week a surgeon at the local hospital scheduled and performed a routine hernia repair.

In *Johnson v. District of Columbia,* a patient with abdominal cramps complained that he had advised the ambulance attendant that he was infected with HIV. The attendant demanded to know "why the hell" the patient had not told him earlier and shouted to his partner upon arrival at the hospital, "He's one of them—one of those AIDS people." The emergency workers dropped the gurney and did nothing to stop the patient from hitting his head.

In *Vermont v. Lunt* the patient complained that two rescue workers failed to respond promptly to his call for assistance. According to the emergency room physician who treated the man, the delay resulted in aggravated brain injury.

In some cases patients were not harmed but complained they had been treated with disrespect and lack of empathy and care. In *Doe v. St. Francis Hospital,* an AIDS patient said she was placed in isolation every time she came to the hospital; her room would not be cleaned and food trays would be left in the hall. Family members were forced to bring her pain medication. Hospital physicians refused to adjust her chest drain and she had to do it herself.

In *Frazier v. Marcus Garvey Nursing Home,* a nursing home patient claimed she was tested without her knowledge or consent. She was not told the results but was placed in isolation, and staff wore masks, gowns, and gloves. She was excluded from all patient activities, and could not use the phone; and a caseworker was fired after trying to help her.

Sometimes the refusal to provide care had little to do with fear of occupational transmission, such as the lab technician who refused to test a patient's blood because "AIDS is God's plague on man and performing the tests would go against God's will" (*Stepp v. Review Board of Indiana Employment Security Division*).

Most decided cases in this area have found that health care professionals have a duty to care for HIV-

In *Hurwitz v. N.Y.C. Commission on Human Rights*, the court answered the question of whether a dentist's private office was covered by a New York handicap statute that provides jurisdiction over places of public accommodation. The court held that places of public accommodation should include clinics, hospitals, dispensaries, and private medical or dental offices (but see *Elstein v. State Division of Human Rights*).

The *Hurwitz* court also answered the question of whether the courts or human rights commissions could review treatment decisions traditionally regarded as within the domain of medical discretion. The court said that there ought to be "due deference" to medical judgments. But the court or commission must balance the need to safeguard human rights and equal access to treatment with recognized medical expertise.

While courts have thus far not been prepared to tolerate treatment refusal based upon health status alone, they have required hospitals to provide education and equipment necessary for health care professionals to practice universal infection control precautions (e.g., *Stepp v. Review Board of the Indiana Employment Security*).

There are, however, potential problems in future cases. Handicap statutes do not protect against discrimination if the health care professional demonstrates there is some risk of contagion. It is conceivable that the courts may be more likely to uphold discriminatory practices in the future where the risk exists but is not significant. An interesting example is presented in *Hartford Hospital Nurses v. Hartford Hospital*. In that case, nurses working on a hemodialysis unit refused to treat AIDS patients until they were provided with "special training, policies, procedures, precautions, and equipment." Dialysis units characteristically involve staff in significant blood exposure. In *Roe v. Cumberland County Hospital System*, an HIV-positive peritoneal dialysis patient with end-stage renal disease required emergency treatment. He had been receiving treatment in New York City, but he claimed he was denied emergency admission to a North Carolina hospital or local kidney dialysis center. He had to travel by bus to Durham, where he was treated at Duke University Medical Center.

Another potential problem may occur under State and local statutes that have a narrow or specific covfusal to treat HIV-infected persons. The court found it was not discriminatory for the doctor to limit his practice to non-HIV-infected patients because of the "unique character" of the physician/patient relationship. It is distinctly possible that other jurisdictions will adopt this approach in the absence of clear statutory language.

In *Walsh v. Cicmanec*, for example, the court will have to decide whether a refusal by a chiropractor to treat comes within the narrow San Diego ordinance that prohibits discrimination by landlords, employers, and businesses.

The HIV epidemic has also opened a perennial legal question about whether there is a legal right to health care. Traditionally, the law will not provide a right to medical services unless they are necessary in emergency cases. To be sure, the health care provider may not discriminate on the basis of a person's serologic status. But what if the refusal to treat does not involve discrimination, but is based upon a valid clinical, research, or financial consideration?

In *Devito v. HEM, Inc.*, an action was brought against a group of researchers and their sponsors who were conducting an FDA approved trial of a new drug (ampligen). The defendants stopped providing the drug because it proved not to be efficacious. The patient, however, believed the drug had stabilized his condition and he sued for the right to continue taking it. The court concluded that the law does not provide a participant in a clinical drug investigation with the power to force the sponsor to provide him with the drug.

Bleyenberg v. Gustafson and Miller also raises the issue of access to a research protocol. The patient was refused admission to a clinical trial when he arrived 45 minutes late. The plaintiff sued (pending) to require the continuation of his medication.

In *Weaver v. Reagen*, medicaid recipients filed suit to force their State to place azidothymidine (AZT) on the Missouri Drug List or to otherwise provide coverage for the drug. A Federal district court held that the propriety of medicaid coverage is determined by the recipient's clinical determination that the drug is medically necessary. That decision has been affirmed by the eighth circuit court of appeals.

In *Dallas Gay Alliance v. Parkland Memorial Hospital*, the hospital clinic maintained a waiting list of patients seeking AZT and pentamidine. Two people

Hcalth carc profcssionals who do want to provide vices for people with AIDS havc somctimes suf- ed discrimination themselvcs. In *Barton v. N.Y.C. mmissian an Human Rights,* a dentist listed his ne with the Gay Mens' Hcalth Center to provide vices for AIDS paticnts. This eventually resulted thc dentist's cviction from his premises. The court d that professionnls offering services could prop- y complain of unlawful discrimination even though professionals themselvcs were not handicapped. e court recognized that objects of discrimination often least able to avail themselves of remedies af- dcd and that discriminatory practices injure socicty a whole. A professional who wants to makc serv- s avnilable to a needy class and who is discrimi- ed against for those cfforts descrves legal protec- n.

Similnr reasoning was used by the courts in *Action S v. Dirot Delaware,* where rcnl estate agents with- ew from property negotiations with a social scrv- s group after thcy learncd that the group's clients d AIDS. The agents withdrew even bcfore request- g thc group's financial records, suggesting that cjudice, not financial concerns, were uppermost in mind of the sellers. See also *Seitzman v. Hudsan ver Assaciates,* where physicians were prevented m moving into an apartmcnt after contracts were gned and lnndlords discovercd they were treating DS paticnts.

The problem with some handicap statutes is that urts will not find them applicable to the buying or ting of commercial establishments. Thus, in *Whit- an Walker Clinic v. Coakley,* the court did not en- rce a contract where the landlords refused to pro- de keys to physicians after they discovered the emiscs would be used for an AIDS clinic.

HIV-infected health care professlonals: testing and nitatlons on the rlght to praetlce

Hospitals and other health care facilities, in rporting to safeguard patients from contracting IV, have sought to identify infected health care ofessionals and sometimes limit their right to prac- e. Handicap statutes were not designed to address is problem and, predictably, courts have not been nsistent in their findings.

Some courts have used traditlonal employment scrimination principles to prohibit testing and termi-

Thc basis for the policy was a mental rctardation hospital's concern about clients who bit or scratched. The court of appeal upheld the lower court's view that the risk to patients was low, "approaching zero."

The court in *Doe v. Attarney General af the U.S.* took a similar approach. The court held that the Fedcral Bureau of Investigation was wrong to terminate a hospital contract because one of the physicians was HIV positive. See also *Department of Health and Human Services an Behalf of Dae v. Charlatte Memarial Hospital,* where thc hospital would not allow an HIV-infected nurse to work until she could prove there was "no risk" to patients, visitors, or other personnel.

F. Insurance

There is an inherent tension in the issuance of health or life insuranee policics to persons infected with HIV. Insurers, seeking to limit their risk, often seek to determine the insurcd's serologic status. This can occur throngh trying to obtain thc results of an HIV test or to determine if there arc any physical conditions potentially related to HIV, such as swollcn lymph glands, low T-cell counts, chronic fatigue and wasting, or rare pneumonias or cancer. HIV-infected persons, on the other hand, have a particular nced for health insurance and many want to providc for their partners or spouses and children through lifc insurance.

Insurance companies and HIV-positive insurancc applicants, therefore, have very different interests. This survey reveals a continuing effort of insurancc companies to ask detailed questions about HIV-relatcd health status, whlle applicants seek to avoid answering those questions directly. Examples includc failure to directly answer questions regarding treatment for anemia and other blood disorders or disorders of the lymph glands (*Zachary Trading Inc. v. Narthwestern Mutual Life Insurance Co.*), treatment for chronic diarrhea, tumor, cyst, or syphilis (*Kentucky Central Life Insurance Ca. v. Webster*), or treatment for hepatitis or a positive test result for HIV antibody (*Lilley v. Protective Life Insurance Company*).

In adjudicating these kinds of cases, the courts usually apply contract law rather than antidiscrimination law. Thus, the central questions are as follows: Did the applicant misrepresent a material fact concerning his or her health history such that its full or correct

have granted the application even if the condition were revealed, the court will uphold the contract. Public policy requires that any ambiguity in an insurance contract will be resolved against the insurer (*Lilley*).

The future trend is likely to be for insurers to ask increasingly more detailed questions to ascertain the person's HIV status. There is no indication that general handicap statutes will be used to void such contracts even if they appear extreme. There are a few State and municipal statutes or insurance regulations that seek to prevent or regulate discriminatory treatment of applicants who are HIV-positive or perceived to be at risk because of their lifestyle.

Examples of extreme conduct could include compulsory testing or "redlining," i.e., refusal to issue policies in certain geographic areas where the insurer believes there is a high proportion of gays or IV drug users (*National Gay Rights Advocates v. Health America*). See also *People v. Health America Corp.*, where the San Francisco district attorney sued an insurance company for advertising for applicants in San Francisco and then refusing to process any applications for health insurance from the city; *Frantz v. Coastal Insurance Co.*, where an insurance company refused to pay for an AIDS-related death even though it had targeted gays in a promotional campaign; and *Murphy v. State Farm Insurance Co.*, where the company refused to provide insurance for the wife and child of a man with transfusion-transmitted HIV.

The strong contract-based analysis of insurance is even clearer when one considers the reluctance of courts even to allow State regulation intended to require fairer treatment for persons with HIV (e.g., *Health Insurance Association of America v. Corcoran*).

XII. Fear of Exposure

This brief section comprises cases that do not fit comfortably in the subject matter outline of the report. The cases, which are grouped together because they involve irrational fears of contracting HIV, include refusal to undergo a blood test to determine paternity (e.g., *Albany Co. Dept. of Social Services on Behalf of Sousis v. Seeberger*) or whether a driver is intoxicated (e.g., *Pearson v. Commonwealth of Pennsylvania*). Other cases include a demand that a homosexual be tested for HIV because he might transmit

litigants are seeking to protect. The first, and overriding, interest is in protection of prison staff and inmates from transmission of HIV. There tend to be relatively high rates of infection in many prisons, possibly because of the backgrounds of prisoners with IV drug use. In addition, a closed environment in which there may be homosexual contact, needle sharing, and violent assaults may be conducive to the spread of HIV.

Although the corrections departments, staff, inmates, and courts all want to achieve the same goal of impeding the spread of HIV, the litigation reflects their profound differences of opinion on the best policies to achieve this goal. Should there be policies in place to compulsorily screen inmates, and to segregate those who test positive from the rest of the prison population? Should there be a duty to disclose positive test results to other inmates and staff? What kind of educational programs should be in place for staff and/or inmates? Should educational programs include graphic explanations of safer drug injection and safer sex, and should officials, for example, make condoms and bleach available?

Litigants seeking greater protection often bring claims against the State or Federal corrections systems for failure to test, screen, segregate, or educate. Inmates have a constitutional right to be protected from contracting communicable diseases that jeopardize their health and well-being. But courts also generally grant correction officials wide leeway in making administrative decisions regarding the health of inmates, unless the failure to act gives rise to a significant risk (e.g., *Jarrett v. Faulkner*).

Virtually all the courts in our survey have found that there is no duty incumbent on correction officials to test, screen, or segregate the prisoners. Several courts have specifically recognized the epidemiologic fact that HIV is not transmitted through casual contact (e.g., *Jarrett v. Faulkner, Glick v. Henderson. LaRocca v. Dalshelm, Mohammed v. Frame, Telepro v. Fauver,* and *Mitchell v. Fox).* Nor is there a public health justification for screening food handlers (e.g., *Feigley v. Jeffes*).

Even in cases where a prison guard failed to take action against a known violent prisoner (e.g., one who had bitten other prisoners), the courts do not find constitutional violations (e.g., *Cameron v. Metcuz*). The standard is set high—the State's failure to protect

potential health hazards in the workplace. The courts have been somewhat more amenable to claims that the corrections department failed to warn prison staff of the risks. In *Delawore Dept. of Correction v. Deloware Public Employees Council 82, AFSCME*, the court held that a labor contract that requires management to provide a safe workplace by notifying the union of the names of HIV-positive inmates was enforceable.

The courts, then, tend to reject most claims of inmates that their health is jeopardized by correction departments' failure to test, screen, or segregate HIV-positive inmates. It may seem counterintuitive, but virtually all courts also reject claims by HIV-positive inmates that their civil rights are violated when corrections departments do require testing, screening, and segregation. The explanation for this is the marked propensity for the courts to uphold the administrative discretion of corrections officials unless their conduct is arbitrary or capricious. The one notable exception is *Doe v. Coughlin*, where the court struck down the establishment of an "AIDS Unit" because it violated the privacy rights of inmates infected with HIV.

Inmates who are compulsorily tested or segregated, or who have their serologic status disclosed, claim various violations of their civil rights. Their first contention is that they have a right to privacy and confidentiality of their medical condition (see, e.g., *Doe v. Columbio County*). The courts found no violation of privacy rights so long as the corrections department produced some evidence that disclosure of the inmate's condition was furthering a valid government purpose. Thus, segregation in an "AIDS Unit," which disclosed an inmate's medical condition (e.g., *Cordero v. Coughlin*), or labeling a patient's record as requiring blood and body fluid precautions (*Baez v. Rapping*) did not violate the inmate's privacy. The reason is that the State has some legitimate interest in promoting the health of the plaintiff, other inmates, or the staff. The courts are not often rigorous in requiring epidemiologic evidence that testing, segregation, or disclosure are reasonable public health interventions. Indeed, court decisions that testing and segregation promote a valid public health interest appear inconsistent when compared to their other decisions that HIV is not transmitted casually.

The courts, however, are more willing to uphold inmates' claims to privacy if the disclosure is not to unreasonable searches and seizures under the fourth amendment. Again, courts have been unsympathetic to this contention. In *People v. Thomos*, the court had no difficulty authorizing either an HIV test on a convicted rapist or disclosure of a positive result to the prison department. Even where a Jehovah's Witness claimed religious objections to the taking of a blood sample, the court upheld the compulsory testing (*Haywood County v. Hudson*).

An important public health question is whether an HIV test can be required as a condition of release on bail. In *People ex. rel. Gloss* the court held that an HIV test could not be required as a condition of bail. Much depends on the facts of the case, and whether the test is relevant to the charge.

In examining the constitutionality of compulsory testing, courts must bear in mind the restrictions placed by the U.S. Supreme Court in its line of cases beginning with *Schmerber v. Collfornia*, 384 U.S. 757 (1966). That case required blood tests to be relevant to the charge or conviction. Thus, testing of persons who are arrested but not formally charged or convicted could be problematic.

HIV-positive prisoners who are the subjects of screening and segregation have put forward a wide array of constitutional claims. Again, the courts usually do not find any violation of the Constitution if the corrections department has a "reasonable medical approach" (*Roe v. Fauver*). Claims under the first amendment have included freedom of speech, association, and the practice of religion while in isolation. Here, all courts observed that first amendment rights of inmates are not unrestricted, and that they are, in any case, outweighed by the State's public health purpose (e.g., *Lewis v. Prison Health Services*; see also *Hoywood County v. Hudson*).

Inmates have claimed under the eighth amendment that their conditions of isolation were cruel and unusual. If the segregation of HIV-infected persons denied them adequate food, clothing, shelter, sanitation, or medical care and safety, plaintiffs would have a valid claim under the eighth amendment (*Cordero v. Coughlin*). But in none of the cases surveyed did the court find a set of facts that warranted such a finding (e.g., *Roe v. Fouver*).

Even where the plaintiff's claim was based upon inadequate medical treatment or misdiagnosis

mate's application to be a subject in an AZT protocol. The court regarded this refusal under the facts of the case as arbitrary.

Inmates' claims under the fourteenth amendment involve equal protection of the laws and procedural due process. The courts in this survey did not uphold equal protection arguments because HIV-positive inmates were not similarly situated to HIV-negative inmates, and the corrections department had a public health purpose (e.g., *Rae v. Fauver, Lewis v. Prison Health Services, Cordero v. Caughlin, Powell v. Department of Correctians, State of Oklahama,* and *Judd v. Packard).*

Most courts also refused to uphold plaintiffs' arguments that they were entitled to procedural due process (a fair hearing) before being isolated. The reason given was that HIV-positive inmates have no "liberty" interest in avoiding segregation. This is because the segregation is intended not for punitive reasons, but to protect their health and the health of others, and because corrections officials have broad discretion in transferring prisoners (e.g., *Muhammad v. Carlsan, Cardera v. Caughlin,* and *Powell v. Department af Correctians, State of Oklahoma*).

The court in *Baez v. Rapping,* however, refused to grant summary judgment against the inmate. The court rested its decision on a New York statute that requires due process before a prisoner is segregated for more than 24 hours.

Courts have also upheld correction departments' decisions not to allow conjugal rights to HIV-infected inmates even if the spouse is informed of the infection (*Dae and Doe v. Coughling*). The court reasoned that, although prisoners have some privacy rights, the right to conjugal relations is not among them.

Finally, the courts have not upheld HIV-infected inmates' claims to be permitted to participate in work programs (e.g., *Williams v. Sumner* and *Haward v. Slansky and Sumner*).

Litigants seeking greater protection often insist on more testing, segregation, and education. Litigants who are tested or segregated claim violations of their civil rights, including first amendment rights to freedom of association or religion, eighth amendment rights prohibiting cruel and unusual punishment, and fourteenth amendment rights ensuring liberty and equal protection. The legal vehicle for many prisoner claims is under the Civil Rights Act, 42 U.S.C. sec-

Department, the plaintiff alleged that officers intimidated witnesses by telling them he might be infected with HIV. The court held that a single instance of misbehavior will not create a violation of civil rights. But in *Fentan v. City of Philadelphia,* the court said that a single instance of egregious behavior may give rise to a cognizable harm under the Constitution. In *Fenton,* the plaintiff alleged that officers willfully attached a memo to his arrest report saying that he had AIDS. He said he was beaten by guards and inmates as a result of the report.

XIV. Special Populations: Military

The HIV-related cases in the military cover many of the same subject matter areas as in the rest of the report. Several military cases are included in other parts of this report. For example, the section on testing and screening provides a review of cases upholding screening programs in the military. The major military cases discussed here are also relevant to other major sections in this report—discrimination, the criminal law, and protection of the blood supply.

A. Discrimination

In *Doe v. Ball,* a Federal district court held that the affirmative action mandate of the Rehabilitation Act does not extend to programs involving uniformed military personnel. This holding, if applied to all claims under the Rehabilitation Act by uniformed military personnel, would preclude most military discrimination cases (see, e.g., *Dae v. Marsh*).

The military is, however, entitled to issue guidelines that require its health care workers to follow infection control procedures and to treat HIV-positive patients. A New York State Department of Labor Appeal Board upheld an initial unemployment office determination disqualifying a dental hygienist employed in an Army-operated dental unit from receiving unemployment benefits because she voluntarily left her employment without good cause to avoid disciplinary action for refusing to treat HIV-infected patients (*In re Panchak*).

1. Conduct discrediting or prejudicial to good order and discipline in the Armed Forces

Article 134 of the Uniform Code of Military Justice prohibits conduct discrediting or prejudicial to good order and discipline in the Armed Forces. In *United States v. Woods*, a Navy hospital serviceman was found guilty of an offense under this article, for engaging in unprotected sexual intercourse knowing that he was infected with HIV and having been counseled regarding his sexual behavior. The Marine Court of Military Review held that although there is no requirement that the serviceman's conduct be prohibited by order or regulation, the act or duty neglected must be one a military person may legally and properly be called upon to perform. The court did not resolve whether consent would constitute a valid defense to the charge, but did conclude that failure to provide notice of HIV infection need not be alleged as an element of the offense.

2. Willful disobedience of a superior commissioned officer

Article 90 of the Uniform Code of Military Justice prohibits the willful disobedience of a superior commissioned officer. HIV-infected servicemen have been charged under this article for disobeying a direct order not to have sexual intercourse (e.g., *United States v. Sergeant* and *United States v. Raantes*).

In *United States v. Negron*, the Army Court of Military Review held that a serviceman violated article 90 by failing to inform his sexual partner, even though he wore a condom.

"Safe sex" orders have been found to be a lawful exercise of command authority because of the legitimate ... accepted by the Army Court of Military Review, even though at the time it was thought that less than 50 percent of HIV-positive persons progressed to AIDS (*United States v. Stewart*).

The key issue in these cases is whether the serviceman's HIV status is admissible in evidence. In *United States v. Crawford*, a military judge found a person's serologic status to be inadmissible under then existing Secretary of the Navy instructions, which have since been changed to allow admission. In *United States v. Grimes*, the Navy-Marine Corps Court of Military Review held that a serviceman's HIV status was admissible to determine whether his bite was likely to produce grievous bodily harm.

4. Making false official statements

The issue on appeal in the U.S. Army Court of Military Review in *United States v. Watson* is whether a serviceman's conviction for making false official statements should stand. The HIV-positive serviceman failed to inform a military medical officer about his medical history.

C. Blood Transfusions From Military Sources

The cases in this section are similar to those already discussed in the section on protection of the blood supply, alleging negligence for failure to adequately screen blood for HIV (e.g., *Doe v. Cutter, Knight v. United States, Phipps v. United States*, and *Valdiviez v. United States*). In the only decided case, the court refused to issue a summary judgment against the United States because at the time of the plaintiff's transfusion there was no established test to detect HIV antibodies (*Valdiviez*).

But the survey does not merely look back to an important part of the history of disease epidemics. It also helps forecast the issues policymakers must be

regulations, create the rights, duties, and limitations that profoundly affect persons infected with HIV and the institutions with which they come into contact.

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